

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-024648

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

3372

STATE FILE NUMBER

FILED JUL 5 1963

|                                                                                                                                                                      |                           |                                                                                                                                                             |                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY Jackson                                                                                                                               |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY JACKSON                                |                               |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN Kansas City                                                                                     |                           | c. CITY OR TOWN KANSAS CITY                                                                                                                                 |                               |
| Length of stay in 1b<br>20 YRS                                                                                                                                       |                           | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                        |                               |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION General Hospital                                                                      |                           | d. STREET ADDRESS (If outside, give location)<br>1528 CORRINGTON                                                                                            |                               |
| Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                                 |                           | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                                       |                               |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Aloysius Middle True Last                                                                                            |                           | 4. DATE OF DEATH<br>Month June Day 13, Year 1963                                                                                                            |                               |
| 5. SEX<br>Male                                                                                                                                                       | 6. COLOR OR RACE<br>White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br>8-13-1910 |
| 9. AGE (last birthday)<br>52                                                                                                                                         |                           | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.                                                                                                               |                               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>WAREHOUSE MAN                                                         |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>S. & J. MFG. CO.                                                                                                       |                               |
| 11. BIRTHPLACE (City and state or country)<br>Ainsworth NEBR.                                                                                                        |                           | 12. CITIZEN OF WHAT COUNTRY<br>USA                                                                                                                          |                               |
| 13a. FATHER'S NAME<br>JOSEPH TRUE                                                                                                                                    |                           | 13b. MOTHER'S MAIDEN NAME<br>Blanche                                                                                                                        |                               |
| 14. NAME OF HUSBAND OR WIFE<br>LORENE SCHWARTZ TRUE                                                                                                                  |                           | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br>NO                                           |                               |
| 16. SOCIAL SECURITY NO.<br>[REDACTED]                                                                                                                                |                           | 17. INFORMANT<br>LORENE TRUE, 1528 CORRINGTON                                                                                                               |                               |
| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Duodenal ulcer, chronic with partial obstruction           |                           | INTERVAL BETWEEN ONSET AND DEATH                                                                                                                            |                               |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.                                                                           |                           | DUE TO (b)                                                                                                                                                  |                               |
| DUE TO (c)                                                                                                                                                           |                           | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)                           |                               |
| PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |                           | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                           |                               |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>                                                            |                           | 20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in PART I or PART II of item 18.)                                                                |                               |
| 20c. TIME OF INJURY<br>Hour a.m. p.m. Month, Day, Year                                                                                                               |                           | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                      |                               |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                             |                           | 20f. CITY, TOWN, OR LOCATION. COUNTY STATE                                                                                                                  |                               |
| 21. I attended the deceased from 5-22-63 to 6-13-63 and last saw her him alive on 6-13-63                                                                            |                           | Death occurred at 2:36 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.                                              |                               |
| 22a. SIGNATURE<br>(Degree or title)<br>[Signature]                                                                                                                   |                           | 22b. ADDRESS<br>2400 Cherry                                                                                                                                 |                               |
| 22c. DATE SIGNED<br>6-14-63                                                                                                                                          |                           | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL                                                                                                         |                               |
| 23b. DATE<br>6-15-1963                                                                                                                                               |                           | 23c. NAME OF CEMETERY OR CREMATORY<br>MT. OLIVET CEMETERY                                                                                                   |                               |
| 23d. LOCATION (City, town, or county) (State)<br>KANSAS CITY MO                                                                                                      |                           | 24. FUNERAL DIRECTOR<br>SNEIL FUNERAL HOME K.C. Mo                                                                                                          |                               |
| 25. DATE RECD. BY LOCAL REG.<br>6-14-63                                                                                                                              |                           | 26. REGISTRAR'S SIGNATURE<br>Ruth N Long                                                                                                                    |                               |

DOCUMENT

BY AFFIDAVIT OF P. Frank Ellis Medical Certification

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

VS 300  
Rev. 4/59

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USE BLACK INK  
OR  
TYPEWRITER RIBBON

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Thomas A. Shaul*

Licensed Embalmer No. 4954

P. O. Address K C MO

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.